THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from Cannabis

THC products: flower, vapes, concentrates, edibles, and hash. A step-by-step route: what to read, in what order, and what outcome the Kernel projects if you follow it.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE.** Plant cannabis withdrawal is real (it is in the DSM-5) but is rarely a medical emergency. The anxiety of early withdrawal can feel like one, and the Kernel's Protocol 01 was written for that state.
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> **If your substance is synthetic cannabinoids (K2, Spice), this guide's detox advice does not apply.** The Kernel says they bind CB1 receptors far more strongly than THC with no ceiling effect, and seizure, cardiac events, and severe psychosis are documented outcomes. Get medical supervision, and see Supp. Ch. 17.
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> **If you are hearing voices, feel paranoid, or lose your grip on what is real, whether or not you have used recently, get a psychiatric evaluation.** Call 911 in an emergency. Crisis: call or text 988 · SAMHSA: 1-800-662-4357

1. Before you start

This is a route through the Recovery Kernel for people whose cannabis use is costing more than it gives, in sleep, motivation, emotional range, clarity, or relationships, and for the people supporting them. The Kernel does not moralize about cannabis or rank it against other drugs. Its position is that cannabis use disorder is one of the most underestimated forms of addiction, and that your biology deserves the same rigorous support as any other. Its core idea is that this is a system that outsourced its regulation: the endocannabinoid system, which governs anxiety, sleep, calm, pain, and creativity, quiets its own production when THC supplies the function. Six rules set the order of everything that follows.

- **The anxiety was there first.** The Kernel says that for the anxious, slow-COMT "Sage" profile and for MTHFR-variant profiles, anxiety is not a withdrawal symptom. It is the condition cannabis was managing, and recovery has to treat it directly.
- **Sleep is the highest-priority protocol.** The Kernel says more people relapse to manage insomnia than for any other single reason, and cannabis suppresses REM sleep, so a REM debt comes due.
- **The dangerous days are the flat ones.** The pull is usually not an acute surge. It is a slow drift toward the familiar solution when anxiety, insomnia, or boredom arrives, and the flat stretch in days 3 to 10 is when most people relapse.
- **Screen for psychosis risk first.** If you have had cannabis-related paranoia, hallucinations, or a psychotic episode, the Kernel's recovery goal is complete abstinence, not moderation.
- **Watch for a swap to alcohol.** The Kernel calls cannabis-to-alcohol transfer the most common and most dangerous transfer for this group.

- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b).

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapter is Chapter 21 (How to Recover from Marijuana and Cannabis-Class Substances). Section numbers (§) refer to sections inside it.

> **A note on protocol numbers.** Supplemental Chapter 21 cites Compendium protocols by number, and some numbers do not match the Compendium as printed. It calls Protocol 04 "Dharma Recovery" (printed: Meeting Alternatives), Protocol 05 both "environmental redesign" and "digital detox" (printed: Digital Detox), Protocol 06 "daily structure" (printed: Phenotype Assessment), Protocol 11 a CBT and nervous-system protocol (printed: Advanced Optimization), Protocol 13 "trigger mapping" (printed: The Pharma Trap), Protocol 17 "Sleep Architecture" (printed: The Nightly Restoration), Protocol 20 the identity protocol (printed: Mapping the Terrain), Protocol 26 "creative practice" (printed: The Vocabulary of Clarity), and Centurian Paper C-31 the long-game paper (printed: Apropos Therapy). This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.
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> For cannabis, the classic version is an edible that “isn’t working” — onset can take up to two hours, and redosing in that window is a common cause of accidental overdose.
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> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first two years. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: psychosis history, synthetic cannabinoids, mood, what form you used.	Supp. Ch. 21 opening, §1, §2 Main Book, Quick-Start Step 1 Compendium P01
1	Days 0–14	Choose abrupt stop, taper, or CBD-assisted. Ride out the Emergence and the Flattening.	Supp. Ch. 21 §1, §3 Compendium P01
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3

Step	When	What you do	Turn to
3	Weeks 1–4	Order 30× whole-genome sequencing. Add a clinical PGx panel and baseline labs.	Supp. Ch. 5 Step 1 Supp. Ch. 21 §2 Compendium P06
4	Weeks 2–6	Resolve your profile. Work out what cannabis was doing for you.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 21 §2
5	Day 1 to Month 6	Build the foundation: anxiety supports, methylation, endocannabinoid supports.	Supp. Ch. 21 §3, §4.1–4.3, §4.5 Supp. Ch. 5 Phase One Compendium P07, P09, P18
6	Days 1–60	Repay the REM debt. Rebuild sleep without REM-suppressing aids.	Supp. Ch. 21 §4.4 Compendium P17; C-32
7	Weeks 1–12, then ongoing	Name the trigger state. Replace the evening ritual. Redesign the cues.	Supp. Ch. 21 §5 Compendium P05, P08, P20, P21
8	Weeks 2–8, then ongoing	Anxiety architecture. Treat co-occurring conditions. Ask about medication.	Supp. Ch. 21 §4.3, §8 Compendium P02, P13
9	Months 1–12	Build your own anandamide: effort, flow, laughter, nature, contemplative practice.	Supp. Ch. 21 §6 C-28; Compendium P04, P19
10	Months 1–6, then Year 1 to 10	Identity after the smoker self. Steward: review, transplant, guide others.	Supp. Ch. 42, 43, 44 Compendium C-28, P24, P25 Supp. Ch. 5 Step 6

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Start with psychosis. Ask honestly: have you had paranoia, dissociation, hallucinations, or an episode while using; is there a family history of psychosis; did you start young; did you use high-potency products daily? The Kernel names two genetic markers it links to risk (AKT1 and COMT) but the clinical history carries more weight: if your history includes any of this, it says cannabis is not a substance you can safely return to, regardless of delivery method or THC level, and that you need a psychiatric evaluation before the supplement protocol begins, since active psychosis is a contraindication for many of its supplements.

Then the form, because it changes the seriousness. The Kernel ranks withdrawal severity by product: traditional flower (mild to moderate), hash (moderate), vape cartridges (moderate to severe: many people vaping are getting far more THC than they realize, so recalibrate your use upward), edibles (moderate from regular high-dose use, with onset possibly delayed 24 to 48 hours because the liver makes a more potent, longer-lasting metabolite), and concentrates such as wax, dabs, and shatter (severe: heavy concentrate withdrawal can approach a moderate-severity substance withdrawal, so treat it seriously). Synthetic cannabinoids are a different, higher-risk category needing medical care.

Turn to: Supp. Ch. 21, opening (the synthetic cannabinoid warning), §1 (the forms table), §2 (the genomic profiles, including AKT1). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state. Supp. Ch. 17 for synthetic cannabinoids.

Step 1 — Choosing a withdrawal plan (Days 0–14)

The Kernel gives the timeline in advance because it changes what the discomfort means. Hours 0 to 24: mild restlessness, irritability, trouble falling asleep, easy to miss. Days 1 to 3, the Emergence: peak irritability, anxiety, insomnia, night sweats, vivid dreams (the return of REM), appetite loss. Days 3 to 10, the Flattening: persistent low mood, anhedonia, fog, disrupted sleep. This is when most people relapse, not from acute craving, but because the colorless quality of life makes sobriety feel worse than the alternative. Weeks 2 to 4, the Gray: gradual improvement with big swings, and returning emotional range, including the ability to feel negative emotions without the buffer, which can itself be destabilizing. Months 1 to 3: recovery becomes viscerally real. Months 3 to 12 and beyond: natural calm and pleasure accessible without chemical help.

Abrupt cessation suits most plant-cannabis users, including heavy ones, because the recovery clock starts immediately. A structured taper is worth considering if you have used several times daily for years, have a co-occurring anxiety disorder, or have failed abruptly before, and it lowers peak intensity while lengthening the process. The Kernel's Case 07 goes further for the anxious profile: address the anxiety biologically first, and use gradual substitution rather than an abrupt stop. Abrupt or tapered, do not go through the Flattening without a plan for it.

> **The Kernel is of two minds about CBD.** Section 3 calls CBD (without THC) a legitimate harm-reduction option that can reduce withdrawal severity, and Case 07 uses it as a bridge to taper. Section 4.4 says to avoid all cannabis, including CBD products, in the first 30 days if possible, so the endocannabinoid system can fully reset. Both come from the same chapter. Decide with your clinician, source pharmaceutical-grade product if you use it, and remember that CBD is metabolized by CYP2C9 and CYP3A4, so poor metabolizers reach higher blood levels.

Turn to: Supp. Ch. 21 §1 (the withdrawal timeline; the amotivational syndrome) and §3 (taper versus abrupt cessation; CBD; the detox supplement stack). Supp. Ch. 2 Case 07. Compendium Protocol 01, Emergency Triage.

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are settled. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT; the slow-COMT Sage or Worrier profile is the Kernel's primary cannabis profile), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Ch. 7 (Harm Reduction), only if you are still using → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 9 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning), which includes Case 07 (cannabis) and Case 11 (cannabis and psychosis) and sets your expectations. Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines for a damaged system. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. A clinical pharmacogenomic panel adds clinical-grade CYP calls. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

For cannabis, the Kernel names **COMT** (Met/Met, the Sage, is the primary profile), **MTHFR**, **FAAH** (C385A: anandamide lingers longer, which brings some natural stress resilience and also faster CB1 downregulation from THC), **AKT1** (see the caution in Step 4), **CNR1** (emerging data, interpretation needs a specialist), **DRD2/ANKK1**, **SLC6A4**, and **CYP2C9** (poor metabolizers feel THC effects two to three times longer, and CBD is also CYP2C9-metabolized). Add DAT1 and DRD4 if you suspect ADHD. Until results arrive: did you use mainly to relax, sleep, or stop an anxious loop; did antidepressants never quite work; did cannabis hit harder or last longer than for others; did you ever have paranoia or dissociation?

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 21 §2 (the genomic profiles; the DNA testing panel for cannabis recovery). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your profile (Weeks 2–6)

The Kernel says cannabis is not one addiction profile but several, and which one you are determines which strategies work. Write your profile down and carry key results on a card.

If your result is...	What changes	Source
COMT Met/Met (Sage)	The brain runs hot and cannot quiet itself. Cannabis was the off switch, and felt like medication more than recreation. Stress management is the central pillar of recovery, not stimulation-seeking.	Supp. Ch. 21 §2; Main Book Ch. 3

If your result is...	What changes	Source
MTHFR plus anxiety	Cannabis filled a neurotransmitter deficit that methylation impairment left. If antidepressants never quite worked, this is why. 5-MTHF is non-negotiable, or the pull stays biological.	Supp. Ch. 21 §§2, 4.1; Main Book Ch. 2
FAAH C385A	Anandamide lingers longer, so baseline anxiety is lower, but CB1 receptors downregulate faster and CUD susceptibility is higher. Prioritize natural anandamide-generating activity.	Supp. Ch. 21 §2
AKT1 rs2494732 C/C, or any psychosis history	The Kernel cites a sevenfold psychosis risk with frequent use and says the goal is complete abstinence, not moderation. Treat this marker with caution: it is not a validated stand-alone clinical test, and your history matters more.	Supp. Ch. 21 §2; Ch. 2 Case 11
DRD2 A1 (RDS)	Cannabis was one of several reward sources, often alongside stimulants or alcohol. Build multiple dopamine sources, and watch for the alcohol swap.	Supp. Ch. 21 §2
SLC6A4 short/short	Higher anxiety sensitivity and higher risk of the cannabis-induced anxiety paradox. Also affects SSRI response.	Supp. Ch. 21 §2
CYP2C9 poor metabolizer	THC effects last two to three times longer, and CBD levels run higher. Relevant to any CBD use in recovery.	Supp. Ch. 21 §2, §8
DAT1 / DRD4 variants	Cannabis is often self-medication for inattentive ADHD. If focus and task completion remain poor at 3 or more months, ask for an ADHD evaluation.	Supp. Ch. 21 §8

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 21 §2. Main Book Ch. 5 and Appendix A.

Step 5 — Build the foundation (Day 1 to Month 6)

The Kernel's foundation has three layers, and the anxiety supports come first. Anxiety and detox: magnesium (the single highest-priority supplement in cannabis detox, for the anxiety, irritability, and insomnia), L-theanine (which the Sage constitution responds to particularly well), NAC, omega-3, 5-HTP (not with SSRIs or SNRIs without a physician), ashwagandha for the stress response, and zinc. Methylation: 5-MTHF, methylcobalamin, active B6, and SAMe as a second-line option, with caution in bipolar disorder because it can trigger mania. Endocannabinoid support: omega-3 DHA (the structural material for receptor recovery), PEA (which works through a parallel pathway without a high), beta-caryophyllene (in black pepper), echinacea alkylamides, and lion's mane for the motivation circuits. The dose tables are in the chapter below. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape). The peptide layer in Supp. Ch. 21 §4.5 is labeled by the Kernel as research compounds needing physician discussion, and it describes Dihexa as very potent with limited human data, so it is not a self-start step.

Turn to: Supp. Ch. 21 §3 (the detox supplement stack), §4.1 (methylation), §4.2 (CB1 receptor upregulation support), §4.5 (peptides, physician only). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 07 (Neuroplasticity), Protocol 09 (The Gut-Brain Axis), Protocol 18 (Eating for Restoration).

Step 6 — Repay the REM debt (Days 1–60)

Cannabis suppresses REM sleep, so every cannabis-assisted night was a night of impaired emotional memory processing. The vivid dreams of early withdrawal are REM rebound, not a symptom to suppress. Expect them for 2 to 6 weeks. Night sweats typically resolve within 7 to 10 days. Sleep may not fully normalize for 4 to 8 weeks, and continued difficulty is expected, not proof that sobriety is unsustainable. Do not reach for other sleep aids that reduce REM. The Kernel's sleep stack (melatonin at a low dose, magnesium glycinate, glycine, L-theanine) supports sleep without suppressing REM, and NSDR (yoga nidra) can help the Sage who cannot quiet the mind. Insomnia is the trigger most likely to send you back, so this step gets no shortcuts.

Turn to: Supp. Ch. 21 §4.4 (sleep reconstruction) and §7 (the protocol map: sleep is the highest-priority protocol). Compendium Protocol 17 (The Nightly Restoration) and Centurian Paper C-32 (The Insomnia Architecture).

Step 7 — The trigger state, the ritual, and the cues (Weeks 1–12, then ongoing)

The craving is not for the drug. It is for what the drug did. The Kernel maps seven trigger states, and each has an alternative: anxiety and rumination (4-7-8 breathing, L-theanine, a cold shower, nature); insomnia (the full sleep stack and NSDR); boredom and flatness (creative engagement, novelty, vigorous movement, and the expectation that the gray passes); social anxiety (preparation, lower-stakes settings first, and the fact that the social ease was partly real and takes time to rebuild); pain (PEA, cold, movement, and, for genuine medical pain, planning with your physician, because blanket abstinence advice fails patients here); creative block (natural flow is deeper, and builds); and the evening ritual, where you replace the ritual, not just the substance, with the same time and place and different content, such as tea, journaling, breathwork, or stretching.

The 5-minute interrupt: name the trigger state; four cycles of 4-7-8 breathing; L-theanine and magnesium if anxiety is the trigger; change one environmental variable; do your highest-intensity natural anandamide activity; and document trigger, intensity, action, and outcome. After three weeks of records you will know your pattern better than any clinician. Cue reactivity is context-specific: the couch at 9 pm, the car on the way home, the friends who smoke. You may need to change more than you expect.

Turn to: Supp. Ch. 21 §5 (the craving trigger map; the 5-minute interrupt). Compendium Protocol 05 (Digital Detox), Protocol 08 (Social Environment), Protocol 20 (Mapping the Terrain), Protocol 21 (Reading the Collapse).

Step 8 — Anxiety, co-occurring conditions, and medication (Weeks 2–8, then ongoing)

The anxiety will not resolve just because the cannabis is gone. The Kernel's tools: extended-exhale (4-7-8) breathing, which works in about a minute; NSDR; a daily cold shower, which builds stress tolerance, the core deficit in anxiety-driven use; and 20 or more minutes in nature, which the Kernel treats as a recognized intervention for the overstimulated nervous system, not a nice-to-have. If anxiety was present before cannabis and remains at clinical levels after 4 to 8 weeks of abstinence, it needs its own treatment, and so does depression that preceded or outlasts the withdrawal. Ask about ADHD if focus is still impaired at three months or more. If PTSD is part of the story, cannabis recovery without trauma treatment is incomplete. Guard against addiction transfer: Compendium Protocol 02 is the Kernel's highest-priority read for this group because of the swap to alcohol.

Most people do not need medication. The Kernel lists those with evidence for cannabis use disorder: NAC (its strongest supplement evidence); CBD (emerging, with the cautions above); gabapentin (short-term use only, in the first one to two weeks of severe withdrawal, under a physician, since it carries its own dependence risk); buspirone (a non-addictive anxiolytic that suits the anxiety-driven profile and takes 2 to 4 weeks); and low-dose quetiapine for severe insomnia in acute withdrawal (time-limited, second-line). These are conversations with a physician.

Turn to: Supp. Ch. 21 §4.3 (anxiety architecture) and §8 (co-occurring conditions; medications with evidence). Supp. Ch. 39 (Complex Trauma and the Substance Connection). Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer), Protocol 13 (The Pharma Trap).

Step 9 — Build your own anandamide (Months 1–12)

Anandamide, named from the Sanskrit for bliss, is your brain's own cannabinoid, and the Kernel says the conditions that release it can be engineered into daily life. Its list: sustained aerobic exercise (30 or more minutes), which the Kernel says is the strongest trigger; deep creative absorption; laughter and social joy, which it says the serious, ruminating Sage neglects and should schedule as deliberately as exercise; dark chocolate and black pepper (low intensity, no cost); nature immersion, at least twice a week; meditation and breathwork, which it says change CB1 sensitivity over time; and intermittent fasting. The Sage's design: a creative practice with depth, a non-negotiable contemplative practice, genuinely demanding movement (the Sage often prefers gentle movement, which is insufficient), deep connection with one to three people, a weekly nature practice, and a project larger than yourself.

Turn to: Supp. Ch. 21 §6 (natural anandamide activation; the Sage's natural addiction architecture). Centurian Paper C-28 (The Recast). Compendium Protocol 04 (Meeting Alternatives, which the Kernel calls Dharma Recovery), Protocol 19 (The Body in Motion), Protocol 29 (The Peacetime Paradox).

Step 10 — Identity and the long game (Months 1–6, then Year 1 to Year 10)

For daily users, cannabis is often woven into identity, so removing it leaves a vacuum. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. The Kernel's picture of the long game: the Sage in full recovery, with a creative practice, a contemplative practice, adequate movement, and deep connection, often reports that the recovered life exceeds the using years in depth of experience. Navigation after the first year shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02. Compendium Protocol 13 (The Pharma Trap). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

Turn to: Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Compendium Protocol 24 (Returning to Work), Protocol 25 (The Open Door), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medical	Psychosis screen; no synthetics	Mood and anxiety medications reviewed [1]	Mood plan, clinician-led	Transfer watch: alcohol, sleep aids [7]
Biology and genome	COMT, MTHFR, FAAH; 5-MTHF base	Retest labs; step stack to upkeep [2]	Prescriber card: COMT, CYP2C9	Re-check with new meds and age
Cues and ritual	Evening ritual replaced	Ritual holds; cues fainter	Triggers: access, friends, normalization [5]	Same plan, rehearsed
Sleep and anxiety	REM debt repaid; anxiety first	Sleep and calm self-owned [3]	Anxiety plan, clinician-led	Stress plan, sleep habits
Anandamide architecture	Aerobic effort; nature, laughter	Flow and craft carry the load [4]	Movement is a lifestyle	Periodized, still daily
Identity and inventory	Identity after the smoker self	Inventory; amends to self	Identity beyond the using years	Annual re-inventory
Meaning and Manning	Purpose: first seeds only	Creative practice; return to work	Manning: guide for others [6]	Mentor or run a group

The seven shifts

1. **Year 3, mood and anxiety medications are reviewed.** The Kernel says co-occurring anxiety, depression, and ADHD need their own treatment, and that some medications (gabapentin, low-dose quetiapine) are meant to be short-term (Supp. Ch. 21 §8). By year 3, review whatever you take using the standard in Compendium Protocol 13: is each still needed, and what marks readiness to stop?
2. **Year 3, the stack moves from building to upkeep.** The Kernel places full CB1 receptor recovery and a recovered endocannabinoid system at months 3 to 12 and beyond (Supp. Ch. 21 §1). Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, sleep and calm are self-owned.** The Kernel describes natural pleasure, creativity, and calm as accessible without chemical assistance by months 3 to 12 (Supp. Ch. 21 §1). By year 3, breathing, movement, and a wind-down ritual are the ordinary way you regulate, not an emergency kit.
4. **Year 3, flow and craft carry the load.** The Kernel calls creative practice the centerpiece of the long game for most cannabis recovery journeys (Supp. Ch. 21 §6.2, §7). By year 3 it is part of your working life, not just an evening substitute.

5. **Year 5, triggers shift to access and normalization.** The Kernel notes that culture normalizes cannabis while pathologizing other drugs, and that cue reactivity is context-specific (Supp. Ch. 21 opening, §7). By year 5, the exposure is a legal, socially routine substance and friends who use. Decide your plan for those settings in advance, and keep Protocol 21 ready. This shift is extrapolation.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). Guiding others, whether through peer support, mentoring, or the project larger than yourself that the Kernel recommends, is where the Sage's depth becomes useful to other people.
7. **Year 10, the standing hazards.** The Kernel calls the swap to alcohol the most common and most dangerous transfer for this group, and says that with a psychosis history the goal is abstinence, not moderation (Supp. Ch. 21 §2, §7). The Kernel also lists harm-reduction goals such as ending daily use for some profiles (Case 07), so this is a decision to make with your clinician and your history, not a default.

What is sourced and what is extrapolated. *Shifts 2, 3, 4, and 7 rest directly on Kernel text. Shift 1 applies a Kernel rule at a timing chosen for this guide. Shifts 5 and 6 are extrapolations. The Kernel's detailed cannabis timeline ends at months 3 to 12 and beyond, and its WHEN Correlator puts deep-root reversal at 2 to 5 or more years for heavy long-term use. Years 3, 5, and 10 are therefore projections.*

5. What outcome to expect

The short version

If you do the route above, with the psychosis screen first, a withdrawal plan you can hold, anxiety supported before or with cessation, the REM debt repaid, the evening ritual replaced, and your own anandamide built, this is the outcome the Kernel projects:

- **You get through the Emergence and the Flattening.** Peak irritability and insomnia fall in days 1 to 3, and the dangerous flat stretch is days 3 to 10. Both pass.
- **By weeks 2 to 4 emotional range is returning,** with big swings. Vivid dreams last 2 to 6 weeks and sleep normalizes over 4 to 8 weeks.
- **By months 1 to 3 the recovery becomes viscerally real.** Activities that felt flat begin to reward, and sleep architecture is substantially restored.
- **By months 3 to 12 and beyond, the endocannabinoid system is at or near baseline with support,** motivation returns, and cannabis "feels like a chapter rather than a current story." The Kernel calls CB1 recovery one of the fastest in addiction medicine.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk or that a return to use cannot happen. It states that the anxiety, sleep, or pain that cannabis was managing must be treated, or the pull stays biological.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Hours 0–24	Day 0	Mild restlessness, irritability, trouble falling asleep. Easy to miss. Edibles may delay onset 24–48 hours.	Supp. Ch. 21 §1	Clinical timeline
The Emergence	Days 1–3	Peak irritability, anxiety, insomnia, night sweats, vivid dreams, appetite loss. The anxiety is real, not imagined.	Supp. Ch. 21 §1	Clinical timeline
The Flattening	Days 3–10	Low mood, anhedonia, fog, disrupted sleep. The period when most people relapse. Night sweats usually end within 7–10 days.	Supp. Ch. 21 §§1, 4.4	Kernel projection
The Gray	Weeks 2–4	Gradual improvement with big swings. Appetite returning. Emotional range widening, which can itself destabilize.	Supp. Ch. 21 §1	Kernel projection
Sleep normalizes	Weeks 2–8	Vivid dreams for 2–6 weeks. Sleep may take 4–8 weeks to normalize.	Supp. Ch. 21 §4.4	Kernel projection
It becomes real	Months 1–3	Significant CB1 recovery. Natural calm and pleasure returning. Cognitive clarity improving. Sleep architecture substantially restored.	Supp. Ch. 21 §1	Kernel projection
System recovered	Months 3–12+	CB1 density recovered and the endocannabinoid system at or near baseline with support. Motivation returns.	Supp. Ch. 21 §1	Kernel projection
Deep-root reversal	2–5+ years (heavy long-term use)	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Creative and contemplative practice. Service. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's own 12-month numbers for two cannabis profiles

Supplemental Chapter 2 gives projected outcomes at 12 months for an adherent protocol compared with standard treatment. Case 07 is a 31-year-old who has used daily since 17, started for anxiety, and has tried to stop twice, each time meeting anxiety she describes as unbearable (COMT Met/Met, the Worrier). The Kernel's point: the anxiety was never properly identified, so stopping without supporting it fails. Case 11 is a 19-year-old who started at 14, is now daily on high-potency products, and has had psychotic episodes. The Kernel says he needs psychiatric evaluation before its protocol begins, and that without cessation the outcome is progressive regardless of protocol.

Case	Measure	Kernel protocol	Standard treatment
Case 07	Cannabis cessation or significant reduction at 12 months	65%	30%
Case 07	Anxiety reduction of 50% or more at Month 6 with biological support	77%	20%
Case 07	Sleep quality improvement without cannabis at Month 3	70%	25%
Case 07	Daily use eliminated (a harm-reduction goal, not full abstinence)	72%	35%
Case 11	Cessation and psychosis-episode reduction at 12 months	70%	25%
Case 11	No further psychotic episodes at Month 6 after cessation	75%	30%
Case 11	Anxiety managed (the original driver of use)	65%	15%
Case 11	Return to educational or vocational function	68%	25%

How to read these numbers. *The Kernel describes them as archetype projections, "probability estimates" for an adherent, biologically confirmed 12-month protocol, drawn from cited studies and NIDA and NICE baselines. They are not guarantees, and the Main Book states that it is not reporting a randomized controlled trial of the Kernel itself. Case 07's protocol includes a CBD bridge with gradual substitution, and Case 11's requires psychiatric co-management.*

What changes the outcome

- **Stopping without supporting the anxiety.** The Kernel says this is almost guaranteed to fail for the anxious profile.
- **Skipping the sleep protocol,** or reaching for REM-suppressing sleep aids. Insomnia is the most common relapse driver.
- **Underestimating your product.** Vapes and concentrates deliver far more THC than flower, and withdrawal can be severe.
- **Ignoring psychosis history,** or returning to high-THC products after an episode.
- **Swapping to alcohol** as the new off switch.
- **Leaving the ritual and the cues in place:** the couch, the car, the friends who smoke.
- **Leaving depression, ADHD, PTSD, or pain untreated.** Withdrawal reveals them, and they do not resolve with cessation.
- **Going through the Flattening without a plan.** Days 3 to 10 feel worse than the alternative, and that is biology, not verdict.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). Note what state was underneath it and adjust the plan.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: cannabis withdrawal, its typical timeline, and the REM rebound are well documented. The Kernel calls NAC its strongest supplement evidence for cannabis use disorder. As I understand the trial record, a trial in adolescents was positive while a larger adult trial was not, so treat NAC as promising and uncertain. The Kernel's AKT1 and COMT psychosis-risk claims are not validated stand-alone clinical tests, and findings on them have been mixed, so rely on your history. Its runner's-high, fasting, and meditation-changes-CB1 claims, the peptide layer, and the years 3 to 10 trajectory sit at the weak end of the scale, so bring them to your clinician as questions, not as facts.

Take these to your clinician

- An honest account of your use: the form (flower, vape, concentrate, edible), how much and how often, since what age, and any alcohol or other substances.
- Any paranoia, hallucinations, or episode when using or not, and any family history of psychosis, so a psychiatric evaluation can be arranged if needed.
- What cannabis was managing (anxiety, sleep, pain, mood, focus, trauma), and a request to treat it directly.
- Your COMT, MTHFR, FAAH, and CYP2C9 results, and every supplement you take, with doses, so interactions can be checked.
- A direct question about NAC, buspirone, short-term gabapentin, and low-dose quetiapine for severe insomnia, and whether CBD is appropriate and from what source.